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CHAPTER FORTY-SEVEN

REHABILITATIVE SERVICES

Chapter 47. Rehabilitative Services

Rule No. 560-X-47-.01. Authority and Purpose.

(1) Rehabilitative services are specialized services of a medical or remedial nature delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness or substance abuse diagnoses. These services will be provided to recipients on the basis of medical necessity.

(2) Direct services may be provided in the client's home, a supervised living situation, organized community settings, such as community centers, health clinics, nursing homes, etc. Direct services can be provided in any setting, except in licensed hospital beds, that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A. Rule effective August 11, 1990; amended August 14, 1991. Emergency rule effective March 1, 1994. Effective date of this amendment June 14, 1994.

Rule No. 560-X-47-.02. Eligibility.

(1) Financial eligibility is limited to individuals eligible for Medicaid under the Alabama State Plan.

(2) Treatment eligibility is limited to individuals with a diagnosis, assigned by a licensed physician or psychologist, of mental illness or substance abuse as listed in the most current International Classification of Diseases - Clinical Modification (ICD-CM). The V codes are not covered for adult rehabilitative treatment services; however, the intake evaluation and diagnostic assessment will be covered even if the resulting diagnosis is a V code. For treatment services provided to children under 21 or adults receiving DHR protective services, the only V code covered for reimbursement is V62.9, unspecified psychosocial circumstance.

(3) Providers of rehabilitative services shall meet the following eligibility requirements:

(a) Shall be in full compliance with applicable federal and state laws and regulations including compliance with the requirements expressed in the current version of the Medicaid Provider Manual, Rehabilitative Services, Chapter 105;

(b) Shall submit evidence to Medicaid of full compliance with 560-47-X-.03; and have such compliance approved in advance; and

(c) Shall execute the Medicaid non-institutional provider agreement with appropriate attachments.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991, March 1, 1994, and June 14, 1994. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.03. Service Providers.
Service providers must demonstrate that they meet the criteria in either (1) OR (2) and both (3) AND (4) below.

(1) A provider must be certified by DMH/MR and must have demonstrated the capacity to provide the following services either directly or through contract with a provider certified by DMH/MR:

(a) A variety of outpatient service types such as individual, family, group, medication administration, medication monitoring, and physician services that are available without regard to the age or the severity of the disorder of the client;

(b) Screening assistance to the courts as evidenced by a written agreement between the provider and the probate court specifying screening procedures for petitions for involuntary commitment to a state psychiatric hospital;

(c) Evaluation for admission to state psychiatric facilities as evidenced by written agreements between the provider and appropriate state hospital specifying procedures for evaluating and coordinating admissions and discharges to state hospitals;

(d) Emergency mental health services available to the general public that are well publicized within the provider's service area and include 24-hour a day telephone and face-to-face response capability;

(e) Consultation and education services designed to inform the general public about the nature of mental health problems and the location of services, to provide consultation to public agencies and private practitioners regarding the treatment of individuals as well as general program consultation, and to provide in-service training to other community resources as requested;

(f) Residential services including coordination with the appropriate state hospital relative to discharge planning and service provision for persons discharged from state hospitals;

(g) Inpatient services through referral to community hospitals and/or through the provider physician serving as the attending physician for community hospitalizations;

(h) Case management services as defined in the Medicaid Provider Manual, Targeted Case Management;

(i) Partial Hospitalization, Intensive Day Treatment, and/or Rehabilitative Day Program as defined in the Medicaid Provider Manual, Rehabilitative Services;

(j) Substance abuse services including intensive outpatient services and residential services.

(2) For individuals under 21 years of age who need rehabilitative services and who are being served by the Department of Human Resources (DHR), the Department of Public Health (DPH), the Department of Youth Services (DYS), or the Department of Children's Affairs (DCA), these state agencies shall also be eligible rehabilitative services providers if they have demonstrated the capacity to provide either directly or through contract an array of medically necessary services. Additionally, DHR may provide these services to adults in protective service tatus. At a minimum this array will include:

(a) Individual, group, and family counseling;
(b) Crisis intervention services;
(c) Consultation and education services;
(d) Case management services;
(e) Assessment and evaluation.

(3) A provider must demonstrate the capacity to provide services off-site in a manner that assures the client's right to privacy and confidentiality and must demonstrate reasonable access to services as evidenced by service location(s), hours of operation, and coordination of services with other community resources.

(4) A provider must assure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Not all services listed above are covered by Medicaid, but the provider must have demonstrated the capacity to provide these services.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX, Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991; March 13, 1993; March 1, 1994; June 14, 1994; and December 12, 1996. **Amended:** Filed October 20, 2000; effective January 10, 2001. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended**: Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.04. Minimum Qualifications for Mental Health, Substance Abuse, and Child & Adolescent Services/Adult Protective Services Professional Staff.

(1) Mental Health Professional Staff qualifications are as follows:

(a) A physician licensed under Alabama law to practice medicine or osteopathy;
(b) A psychologist licensed under Alabama law;
(c) A professional counselor licensed Alabama law;
(d) A marriage and family therapist licensed under Alabama law;
(e) A certified social worker licensed under Alabama law;
(f) A registered nurse who has completed a master's degree in psychiatric

nursing;

(g) An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who:

1. has successfully completed a practicum as a part of the requirements for the degree; or

2. has six months post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience as described in DMH/MR standards;

(h) Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the Medicaid Provider Manual, Rehabilitative Services.

(i) A pharmacist licensed under Alabama law may provide medication monitoring.

(2) Substance Abuse Professional Staff qualifications are as follows:

(a) Clinical screening and assessments of a substance abuse client shall be performed by a person with at least two years substance abuse treatment experience and meeting any one or more of the following:

1. A person licensed as a physician, psychologist, certified social worker, or counselor; or

2. A person with a master's degree in a clinical area.

(b) Treatment planning and counseling of substance abuse clients shall be performed by any one or more of the following qualified professionals:

1. A person who meets the qualifications stated in (2)(a) above;

2. A person with a master's degree in a clinical area with a clinical practicum;

3. A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting;

4. A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience;

5. A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience based, voluntary credentialing process. Such certification must have mutual reciprocity with surrounding states and be nationally recognized. Services will be provided by practitioners as defined above consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law.

(c) Services rendered to persons with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the Medicaid Provider Manual, Rehabilitative Services.

(3) Child and Adolescent Services/Adult Protective Services Professional Staff qualifications are as follows:

(a) A physician licensed under Alabama law to practice medicine or osteopathy;

(b) A psychologist licensed under Alabama law;

(c) A professional counselor licensed under Alabama law;

(d) A marriage and family therapist licensed under Alabama law;

(e) A social worker licensed under Alabama law;

(f) A registered nurse who has completed a master's degree in psychiatric nursing;

(g) An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who:

1. has successfully completed a practicum as a part of the requirements for the degree; or

2. has six months post master's level professional experience supervised by a master's level or above with two years of post graduate professional experience.

(h) Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105.

(i) A pharmacist licensed under Alabama law may provide medication monitoring;

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991; March 1, 1994; and June 14, 1994. **Amended:** Filed October 20, 2000; effective January 10, 2001. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X- 47-.05. Requirements for Client Intake, Treatment Planning, and Service Documentation.

(1) Requirements for intake, treatment planning, and service documentation are detailed in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105, Section 105.2.3. Manuals may be downloaded from the Medicaid website at www.medicaid.state.al.us.

(2) Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested shall comply with any applicable certification or licensure standards and shall include, at a minimum:

(a) the identification of the specific services rendered;

(b) the date and the amount of time that the services were rendered;

(c) the signature of the staff person who rendered the services;

(d) the identification of the setting in which the services were rendered;

(e) a written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed.

(3) The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

(4) When clinical records are audited, the list of required documentation found at 560-X-47-.05(2) will be applied to justify payment by Medicaid. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130(d), 482.24; Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987; P.L. 100-203, Section 4105; State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended March 1, 1994; and June 14, 1994. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended**: Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.06. Covered Services.

(1) Only the following rehabilitative services shall qualify for reimbursement under this program.:

(a) Intake Evaluation,
(b) Physician/Medical Assessment and Treatment,
(c) Diagnostic Testing,
(d) Crisis Intervention and Resolution,
(e) Individual Counseling,
(f) Family Counseling,
(g) Group Counseling,
(h) Medication Administration,
(i) Medication Monitoring
(j) Partial Hospitalization,
(k) Adult Mental Illness Intensive Day Treatment,
(l) Rehabilitative Day Program,
(m) Mental Illness Child and Adolescent Day Treatment,
(n) Treatment Plan Review,
(o) Mental Health Consultation,
(p) Adult Substance Abuse Intensive Outpatient Services,
(q) Child and Adolescent Substance Abuse Intensive Outpatient Services,
(r) In-home Intervention,
(s) Prehospitalization Screening,
(t) Basic Living Skills,
(u) Family Support,

(v) Assertive Community Treatment (ACT),
(w) Program for Assertive Community Treatment (PACT),
(x) Methadone Treatment.

(2) A complete description of each covered service along with benefit limitations is contained in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105. Quarterly manual updates may be downloaded from the Medicaid website: medicaid.state.al.us.

(3) Services shall be provided in a manner that meets the supervisory requirements of the respective certifying or licensing authority or as authorized by state law.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130(d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987; P.L. 100-203, Section 4105; State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991; March 13, 1993; March 1, 1994; and June 14, 1994. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended:** Filed October 20, 2000; effective January 11, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.07. Payment Methodology.

(1) The Medicaid reimbursement for each service provided by a rehabilitative services provider shall be based on the following criteria as found in 42 CFR Sections 447.325 and 447.304 and shall not exceed the lower of:

(a) The customary charges of the provider but not more than the prevailing charges in the locality for comparable services under comparable circumstances; or
(b) the amount billed; or
(c) the fee schedule established by Medicaid as the maximum allowable amount.

(2) Reimbursement for services provided by state agencies under the provision of 560-X-47-.03(3) will be based on actual costs as follows:

(a) Agencies will submit an annual cost report not later than 60 days following the close of the fiscal year. This report will indicate not only the costs associated with providing the services, but also statistical data indicating the units of service provided during the fiscal year.
(b) Cost reports will be reviewed for reasonableness and an average cost per unit of service will be computed.
(c) The average cost, trended for any expected inflation, will be used as the reimbursement rate for the succeeding year.
(d) If the cost report indicates any underpayment or overpayment for services during the reporting year, a lump sum adjustment will be made.
(e) New rates will be effective January 1 of each year.

(3) Actual reimbursement will be based on the rate in effect on the date of service. Only those services that qualify for reimbursement will be provided under this program.

Authority: 42 CFR Section 447.304 and 447.325; Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 4.19-B. Rule effective August 11, 1990; amended August 14, 1991. Emergency rule effective March 1, 1994. Effective date of this amendment June 14, 1994.

Rule No. 560-X-47-.08. Third Party Liability.

(1) The rehabilitative services provider shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of liable third party source, utilize that source for payments and benefits prior to applying for Medicaid payments.

(2) Third party payments received after billing Medicaid for service for a Medicaid recipient shall be returned to the Alabama Medicaid Agency.

Authority: 42 CFR Section 433.135; Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 4.19-B. Rule effective August 11, 1990; amended August 14, 1991.

Rule No. 560-X-47-.09 Payment Acceptance.

(1) Payment made by Medicaid to a rehabilitative services provider shall be considered to be payment in full for covered services rendered.

(2) No Medicaid recipient shall be billed for covered Medicaid services in part or in full for those services rendered, billed, and paid to the provider by the Medicaid fiscal agent. These services are exempt from copays.

(3) No person or entity, except a liable third party source, shall be billed for covered Medicaid services in part or in full.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 447.15; Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990; amended August 14, 1991. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.10 Confidentiality.

(1) A rehabilitative services provider shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning a

recipient, except upon the written consent of the recipient, his attorney, his guardian, or upon subpoena from a court of appropriate jurisdiction.

Authority: 42 CFR Section 431.306; Social Security Act, Title XIX; State Plan for Medical Assistance, Attachment 3.1-A. Rule effective August 11, 1990; amended August 14, 1991.

Rule No. 560-X-47-.11 Records.

(1) The rehabilitative services provider shall make available to the Alabama Medicaid Agency at no charge all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Complete and accurate rehabilitative and fiscal records which fully disclose the extent of the service shall be maintained by the provider. Said records shall be retained for a period of three years plus the current year and/or until completion of any audit.

(2) Documentation of Medicaid clients' signatures may be entered on a sign-in log, service receipt or any other record that can be used to indicate the client's signature and the date of service. Treatment plan review, ACT, PACT, prehospitalization screening, crisis intervention, family support, mental health consultation, and any non-face to face services that can be provided by telephone do not require client signatures.

(3) Documentation failing to meet the minimum standards noted in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105, will result in recoupment of payments.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 431.17, Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990; August 22, 1990; August 14, 1991; March 1, 1994; and June 14, 1994. **Amended:** Filed October 20, 2000; effective January 11, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.